Lente (F. D.)

SUPERFICIAL LACERATIONS

OF THE

PERINEUM.

BY

FREDERIC D. LENTE, M.D.,

Vice-President New York Neurological Society; Member of American Neurological Association; of American Public Health Association; Hon. Member of North Carolina State Medical Society; Corresponding Member of New York Medical Legal Society; Member of Board of Managers of Hudson River State Hospital, &c., &c., &c.

Read before the New York Obstetrical Society.

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LACERATIONS OF THE PERINEUM.

Dr. F. D. Lente, of Cold Spring, read the following paper on

INCOMPLETE LACERATIONS OF THE PERINEUM.

Since so little has been said in our systematic treatises, and even our periodical literature, about lacerations, and especially incomplete lacerations of the perineum; and since the attention of the profession has been attracted to this subject by Dr. M. D. Mann, in the October number of the American Journal of Obstetrics, with an implied call for additional information and statistics, I propose to give briefly the results of my own observations in the hope that others, who may have had a larger experience in obstetrics, may follow the example, and endeavor to set this question at rest, and to establish some principle of action. For, as the matter now stands, it is a difficult question for a young practitioner to decide when he finds himself at the threshold, perhaps, of his obstetrical practice, confronted by a considerable laceration of the perineum, probably after an instrumental delivery; the matter being still more embarrassing if it has occurred in a family of influence. If he should call in neighboring consultants of larger experience, his dilemma would not likely be resolved, as a disagreement would probably be the result, and the notoriety given to the occurrence would only enhance his embarrassment. What then shall he do? He will turn over the leaves of his authorities, if he happen to have a good library, in vain. That is my experience in other difficulties besides this; and, until authors write more from their case-books, and are less guided by mere memory of experiences long past, it will continue to be so.

If the laceration extend through the sphincter ani, and through that triangular space called the perineal body, so ac-

curately described by Dr. Thomas, and thus lay the rectum and vagina into one cavity, we may take it for granted that operative interference will sooner or later be required. Probably there would be no difference of opinion here. But what shall be done with the cases of "superficial" laceration? It is only to these that Dr. Mann has called attention.

In the first place, as regards their frequency, my own experience accords with that of others quoted by Dr. Mann. It is quite common in *primiparæ*, and after forceps. Moderate cases are, as he says, doubtless constantly overlooked, and I think fortunately so. Dr. Stokes, long ago remarked, in the case of the complication of pneumonia with typhoid fever, it is usually fortunate that the practitioner fails to recognize it, as he might be tempted to treat it. We have somewhat better ideas now of therapeutics, and we know that generally the pneumonia will take care of itself if we can manage the fever. So it is, in my opinion, with these lacerations.

In the next place, how does it occur? For, a knowledge of the cause may lead to prevention, and this is better than cure. The causes which are *generally* recognized we need not stop to consider. Dr. Mann enumerates three. Then he remarks:— "Many perinea are ruptured by a careless delivery of the shoulders after the head has passed." This is so. But many are ruptured by the shoulders which are *not* attributable to carelessness. And as too strong an assertion on this point might lead to annoying suits for malpractice, especially in neighborhoods cursed by a doctor given to fostering such suits, it is well that it should be understood that a ruptured perineum, even after an instrumental delivery, does not by any means imply any want of skill or care on the part of the accoucheur. The burden of proof in such cases ought to rest on the prosecution.

Not long since, in a prominent journal, I read an article by a physician of apparently large obstetrical experience, in which he contended that rupture was scarcely ever, if ever, attributable to the passage of the shoulders. Singularly enough, in the same number was a table containing a large array of statistics, showing that this is an exceedingly common cause; and so in my experience it is; in my forceps cases especially (and it is here that it would be most likely noticed when it occurs), it has been the shoulders which have done the damage. I have demonstrated this more than once to my assistants, that the head had passed safely, that the forceps had been removed, and that a bad laceration has then been produced by the shoulders. A good deal of stress is sometimes laid on the importance of removing the forceps before the head passes the perineum;

but a little examination will show that, although this may easily be done, it is of no consequence, as the blades cannot appreciably increase the diameter of the head, as they would do were they solid instead of fenestrated.

Granting that the shoulders are the dangerous portion of the fœtal body, and it is conceivable that a comparatively sharp object *should* be so, rather than a globular one—what can be done to avert the catastrophe. "Supporting the perineum," in the ordinary acceptation of the term, would only make matters worse, as it always does, by stimulating reflex action. The only feasible plan would seem to be to retard the advance of the presenting part as much as possible, and endeavor to ease it through gradually pressing it forward also, perhaps, as it is passing.

Now, as regards *what should be done when the laceration has occurred.* As I have before hinted, if moderate—that is, in linear extent—it will, except in instrumental cases, most likely be overlooked; and fortunately, as it will save the patient a good deal of worry, and the doctor also, if he be inexperienced. If it extend nearly to, or quite to the sphincter ani, and perhaps a little around one side of the anus, what shall be done? This is the point which needs to be better settled than it is. I only design to give my own experience, and make no reference to that of others. Others have indeed said too little about it. My first case disturbed me very much, and I worried and alarmed my patient and her friends not a little by stating pretty positively that, although no danger need be apprehended, an operation at some future time would be necessary. Weeks after the accident, although the patient had had no particular care, and no unusual precautions were taken, the wound had healed, and the patient appeared to feel no inconvenience. This has been my fortunate experience ever since in a good many cases; for I do not agree with Dr. Mann that these accidents may always be prevented. Among the poor, I have not even given directions for keeping the patient on her side in order to prevent the urine and lochia from irritating the wound, because they would probably not regard them if I did, and they are seldom necessary.[1] It is astonishing how little suffering such a wound occasions. In one case, I remember, in which Dr. Murdock of this place assisted me, I delivered with the forceps, and showed him that not the slightest laceration had occurred from the passage of the head, and that, as the shoulders passed, the perineum was rent quite to the sphincter ani, extending a little around one side of the

[1] There *is* one precaution which is important, and which I always enjoin, the *recumbent posture* for at least nine days; but this is also insisted on in ordinary cases, though not always observed.

anus. It was rather a nice patient, a primipara, and as she had a competent nurse, I considered it best to acquaint both with the occurrence, merely to insure extra cleanliness. I might as well have kept it to myself, as the patient felt not the slightest inconvenience from it. Months after, I examined the parts carefully, in a good light, and positively could not discover a trace of the accident. Even the fourchette appeared perfect. This is of course an exceptional case. It is generally easy to see the cicatrix, if one looks for it carefully. I will briefly refer to a more astonishing case than this, though it did not occur in my own practice, but it should be put on record, since Prof. Thomas does not admit, in the last edition of his now justly celebrated treatise on Diseases of Women, that there is any well-authenticated history extant of such a case. I have remarked that it must be taken for granted that a laceration through the sphincter ani must be operated on. But even this has its exceptions. Some years ago two of my intimate professional acquaintances were interested in such an exceptional case. One was the late Prof. Geo. T. Elliot, the other Dr. John G. Perry. The vagina of this lady was the smallest and most rigid which Dr. E. had ever met with, which led him to caution her friends that laceration would probably occur. It became necessary to resort to the forceps, and although he used the smallest and lightest in his possession, and all the usual skill and care for which he was distinguished, an appalling laceration did occur, splitting the sphincter ani and the vagina *throughout its whole length to the bottom of Douglas' cul-de-sac.* He was of course horror-struck at its magnitude, and naturally solicitous to repair damages at once. But Dr. Perry, whom he strenuously urged to operate, very properly, in my opinion, although specially qualified to do so, declined to accede to his request. His own cooler judgment told him subsequently that it would not have been prudent, and the unlooked-for result proved that it would have been entirely unnecessary. The patient's bowels were not kept confined by opium, as is usually enjoined in such cases, but were solicited to act regularly by enemata. Dr. Elliot afterwards informed me that this extensive wound healed promptly, spontaneously, and thoroughly. He attributed the spontaneous healing of the vaginal portion to the firm and rigid condition of its walls, the very circumstance which doubtless led to the accident. Dr. Perry has since attended this lady in a confinement which presented no unusual difficulty, and the perineum has stood the test a second time in Paris. Her health has continued good.

I was writing this paper for occupation, while detained at the house of a patient with the most tedious case of labor which it

has been my fortune to encounter, with one exception, and was interrupted just at this point by the necessity for employing the forceps, and a means was thus offered me on the spot of exemplifying some of the ideas previously expressed in this paper. Dr. Murdock, my assistant in practice, had been summoned a few hours before to assist me in the use of first Molesworth's and then Barnes' dilator for facilitating the dilatation of an unusually rebellious os, and had been allowed to depart, so I had to operate alone. The head was unusually large (the child weighed 10¼ lbs.), and with all my care in imitating, as far as possible, the natural process, there being a good light on the parts, I saw the perineum tear slowly to the extent of an inch or more in the median line. I was almost certain that the shoulders of so large a fœtus would extend this to the spincter ani at least, but pursued the plan, the description of which, singularly enough, had been written scarcely an hour before—that is, to press the shoulders forward towards the arch of the pubes, and upward in the axis of the vagina. This was perfectly successful, as I was gratified to see, while closely observing the part, that there was no further injury inflicted. Indeed, this manœuvre seemed to take almost all the strain off the perineum.

Of course every one of any considerable experience knows that it is not uncommon to see a short perineum resulting from these rather extensive lacerations, and causing a good deal of trouble, a want of support to the vagina, prolapsus of rectum and uterus, and retroversion, congestion, etc., and that *perineorrhaphy* is the only radical cure when these annoyances are of sufficient importance to render a resort to operation advisable. It is, however, under these circumstances one of the simplest, safest, and most successful of surgical procedures. But the case would be far different were it done immediately after labor, which, in such cases, is apt to have been a protracted, an instrumental, and perhaps a complicated one. Drs. Joulin and Mann give unanswerable reasons, I think, for not resorting to primary operation. One recommendation of the latter we may adopt with benefit, perhaps, and without attracting the patient's attention to her condition: to have the ordinary binder broad, and let it extend well down below the trochanters, as indeed it always should do. This, if tightened daily, will restrict the movements of the lower limbs sufficiently, and thus, to some extent, prevent motion of the edges of the wound. His suggestion of what he terms the "Vienna method" in such cases as extend to, or nearly to the sphincter, is also probably a good one, viz., to apply strong *serrefines* to the edges of the laceration. It would appear from Dr. Mann's cases at the Vienna Hospital that

union is more apt to occur, whether they are used or not, in private practice than in hospital, as might be anticipated.

Dr. T. G. Thomas said that he was opposed to operating at once in such cases as the one observed by Drs. Perry and Elliot, and quoted by Dr. Lente, because the patient is too much exhausted, and the union of the laceration too extensive an operation for her already enfeebled system. Smaller lacerations to or merely through the sphincter ani should be closed at once; still smaller ruptures than these last require no treatment. A general rule whether to operate immediately or follow the plan of non-intervention, can scarcely be made. The only general rule he knows of in this connection is this: There are four varieties of laceration of the perineum. 1. A slight distance into the perineum; 2. To the sphincter ani; 3. Through the sphincter ani; the last two require immediate operation; 4. Some distance up the rectum; these should not be touched, as there is little prospect of success to be expected from an immediate operation.

Dr. Lusk said that in his experience the proportion of cases of success after the immediate operation in hospital practice was about one-half.

Dr. Lee said that there was some difficulty in determining the exact extent of the laceration when the parts were swollen and turgid, as they usually are, immediately after labor; that he had seen an apparently small laceration appear a very large one when the swelling subsided.

Dr. Mundé said that in his experience, which had been quite large in this respect, he had found that, on the contrary, lacerations usually appeared larger immediately after delivery, when the perineum was distended and the vulva swollen, and that they diminished in size after a day or two when the parts had regained their normal relations. He had repeatedly seen lacerations of ½ to 1″ in length unite by merely tying the legs together, passing no catheter, but letting the patient urinate over the perineum, and then pouring warm water over the external genital organs. He had also seen ruptures, which did not unite after immediate suture, heal by second intention during the remainder of the lying-in period. In the Lying-in Hospital at Würzburg, Bavaria, under Prof. Scanzoni, all perineal lacerations were immediately closed by thread or silk sutures, and with very good results. Dr. Mundé thought that of the cases operated on by him from ½ to ⅔ recovered; one, he remembers, so perfectly as to show no trace whatever of the line of union. The method of immediate operation is so universal in Germany,

that Dr. Mundé was surprised on hearing that the question was still an open one in this country.

On motion of Dr. Noeggerath, it was moved to continue the discussion at the next meeting.

Stated Meeting, March 23, 1875. The President, Dr. Byrne, in the Chair.

Dr. Noeggerath opened the discussion on the

TREATMENT OF LACERATION OF THE PERINEUM

by reading the following paper:

After the discussion on ruptured perineum at the last meeting of this Society, it appeared that the statement made by Dr. Lente as an introduction to his paper on the lesion in question, had remained almost in *statu quo*. He remarked:

"As the matter *now* stands, it is a difficult question for a young practitioner to decide, when he finds himself at the threshold, perhaps, of his obstetric practice, confronted by a considerable laceration of the perineum."

It was therefore resolved to continue the discussion on that important topic, and I will take this occasion to contribute my share in the matter as far as I am able to do so. I will first briefly touch upon the proceedings which have been mentioned during the discussion—proceedings for which it is claimed that they were apt to prevent rupture of the perineum.

The first, which was incidentally mentioned, has been usually designated as Ritgen's Manœuvre. It consists in the expulsion of the head by means of two fingers placed in the rectum. It was, however, recommended already in 1781, by Drs. C. L. Hofman and Hagen, and by Smellie as far back as 1754. It seems, however, not to have received the attention due to it, perhaps, from its reliable efficacy. Dr. Ahlfeld has lately again pointed out the great value of this manipulation in the Archiv für Gynæcol., vol. vi., No. 2, 1874. Its principal object is to force the head into a space near the symphysis pubis, which is usually not occupied in the ordinary process of parturition. In this manner the head is lifted to a considerable extent away from the perineum. Another advantage of this proceeding consists in the fact that the perineum is kept succulent in the interval as it is during a labor-pain, in consequence of which the tissues become relaxed. With Ahlfeld quite a number of prominent obstetricians employ it with success at the present day.

The value of the second proceeding, scarifications and inci-

sions of the perineum, although spoken of in the highest terms by some authors, has not been so successful in the hands of others. Dr. G. F. Abegg, Chief of the Royal School for Midwives at Danzig, speaks of it in the following manner: "The lateral incisions of the perineum I consider entirely useless. I used to employ them frequently in former times, but I have become convinced that in those cases where the perineum was not ruptured, it would not have suffered even without the incisions. On the other hand I have seen, after very large lateral incisions, such extensive lacerations of the perineum, that they could not have been larger without the use of the bistouri."

The able article of Dr. M. D. Mann, in the American Journal of Obstetrics, has been the primary incitement to Dr. Lente's paper, as well as to our discussion, and it would seem that the very fact of its calling forth a discussion on this subject is proof sufficient that the proposition laid down in his paper has not had the influence with our specialists which it was expected to exercise, from its scientific value as well as from the confidence placed by the author in the recommendations resulting from its contents. This reasoning is strengthened by the tenor of the discussion at our last meeting. The members of this Society were evidently not convinced of the value of the serres-fines in the treatment of ruptured perineum. They have been weighing the arguments *pro* and *con* of all other proceedings to the exclusion of this apparently simple method of treatment. The *à priori* reason of this fact seems to me to be founded in the conviction that such a grave and serious lesion as a deep rupture of the perineum would not find means of repair in the application of a few serres-fines.

I will here remark that the term "superficial" rupture of the perineum in the heading of Dr. Mann's article is a misnomer for the lesion which he describes, inasmuch as he designates by that name those ruptures which reach up to the sphincter ani muscle. Now, when all of the tissues of the perineum are involved, we can no longer call it a superficial rupture.

What then is the value of serres-fines in complete rupture of the perineum?

Let us first see what Prof. C. Braun, the head of the Vienna School, which seems to have monopolized their use in our days, has to say about their application. In his well-known Klinik der Geburtshülfe und Gynæcologie he says: We also have seen their use followed by the desired result in many cases. In other instances, however, this method of closing the rupture has no good effect at all. After describing the conditions under which they must be applied, he goes on to say: A corroding discharge or restlessness of the mother more frequently

prevents the success of the method. Patients of irritable constitution do not support them at all, since the application as well as the changing of the clamps is pretty painful.

Serres-fines have been employed pretty extensively all over Germany, but apparently abandoned at the present time. Hoogeweg, of Berlin, cured 27 out of 38 cases. At the Maternité, in St. Petersburg, 12 were cured out of 82 cases, while Grenser had no success at all with them. Prof. Winckel employed them in 36 ruptures occurring in the Clinic at Rostock, 17 of which were healed more or less completely. According to his experience, they produce pain for a longer time than sutures, while they cut through just as readily as the latter, and where their ends are attached they are apt to cause ulceration.

Prof. B. Schultze, the successor of Hoogeweg, tried them faithfully at first, but abandoned them finally for the suture, because the results from the latter proceeding far exceeded those of the former.

With the knowledge of these facts and opinions before us, it is proper to say, that the value of serres-fines is far from being established sufficiently to recommend them as *the* measure to be adopted in the treatment of deep rupture of the perineum.

What then is the proper treatment for these cases? It has been suggested in the paper by Dr. Lente, that it might be the best plan for the physician to ignore the existence of a rupture, partly on account of the possible injury done to the reputation of the attending physician, partly on account of the fact that a great many cases heal spontaneously. With regard to the former point, it is my firm conviction, that in framing therapeutical indications the welfare of the doctor should never be taken into consideration. Moreover, I believe that the damage done to the profession at large would be greater, if physicians were to ignore the existence of the lesion, and leave it to the patients to find out their condition afterwards—than if the accoucheur would deal fairly with every one of those that have confided their welfare into his hands. Let the physician prepare the friends and relatives of the patient for the possibility of such an occurrence, and quiet them with the assurance that he will put forth his best endeavors to avoid the accident. Should it then take place after all, he will not be blamed for ignorance or want of proper care.

True, a large number of ruptures do heal up without any interference. But all authors agree at the present time that the parts, although healed over, are not reinstated to their natural condition; that they are unfit to perform the physiological functions allotted to them. The drawbacks for the future welfare

of the patient have been sufficiently pointed out again and again by writers on gynecology, that I refrain from repeating them on this occasion.

What, then, is to be done in the presence of a rupture of the perineum? Nowadays there is not a dissenting voice among the leading obstetricians. To prove this I quote the words of Prof. von Hecker, of Munich. He says:

"In no department of the obstetric science have the views been advanced and corrected so much during the last twenty years as in the prophylactic and curative treatment of rupture of the perineum; almost all over Germany the same principles are represented, and it is fair to say that the questions on which there exist different opinions are of decidedly minor importance. In my opinion," he goes on to state, "the right way to manage every rupture, is the application of the suture as soon as possible after delivery."

The reason why the early operation had been abandoned for some time, as a most unreliable proceeding, is explained by the want of knowledge of those conditions that are requisite to insure success; and in the same measure as operations for other lesions of the female genital organs—that for vesico-vaginal fistula, for instance—have received an incredible impetus in consequence of our improved means of operating, in the same measure the opinion has been generally adopted, that the immediate suture in all cases of rupture of the perineum is the only rational method of treatment. Prof. Hecker gives a report of the success of the immediate operation of forty-two ruptures, which took place among 1,584 deliveries, nine of which involved all the parts up to the anus, without injuring the sphincter; twenty-eight were cured entirely, four partially, ten did not heal up.

From the reports of the Lying-in Hospital of Dresden, published by Prof. F. Winckel in 1874, it appears that thirty-two ruptures, three of which reached to the sphincter, occurred in 1868 after 775 deliveries. The operation was followed by complete success in twenty-two cases, by partial success in three, while seven remained open. In 1869, among 739 confinements, forty-five ruptures took place, one of which passed completely through the sphincter ani; thirty-eight of these healed entirely by first intention, two only partially, no success in four cases, one was operated later. In 1873, 1011 women were delivered; the perineum was ruptured 115 times. In fourteen cases the lesion was not severe enough to call for interference. In 101 cases the immediate operation was performed, and apparently with full success. The report does not mention the contrary, nor does another report on the condition of the patients,

when they left the hospital, from the 10th up to the 20th day after delivery, mention the existence of a single ruptured perineum.

Dr. G. F. Abegg, of Danzig, performed the operation in all of the ruptures to the number of sixty-eight among 908 births; forty-two healed up completely, twenty-two only partially, four were not cured on account of puerperal ulcerations of the vagina. Prof. Schroeder reports the success of the operation in eighty cases. Of these, twenty-seven healed up entirely by first intention, seventeen others were perfectly united, but granulated on the surface, fifteen were united in the deeper layers of the perineum, in fifteen the operation was unsuccessful, the result in six cases not known. He ascribes these not very favorable results to the fact that the operations were all performed by students, who did them neither with sufficient experience nor accuracy.

From the report of the Lying-in Hospital at St. Petersburg, published by Dr. E. Bidder and Dr. W. Sutigin, it appears that 126 ruptures were united by sutures, which occurred after 1998 deliveries. Among these sixty healed by first intention, thirty-four partially, twenty-nine were not cured, the result in three remained unknown. The unsatisfactory result is also attributed to the fact, that the operations were performed mostly by inexperienced young physicians.

The best success was obtained by Prof. von Holst, of Dorpat, Russia, who claims to have closed up by first intention every single case in which he performed the operation. The same good results are claimed by Prof. B. Schultze, who succeeded in uniting all of the thirty deep ruptures, upon which he operated immediately after confinement, with the exception of two, where the process of healing was interfered with by puerperal ulcerations in the vagina.

From a calculation of the results of these various statistics it would appear that complete success is obtained in about seventy-five out of every 100 cases.

Now, if we recommend the immediate operation, this does not exclude the admission of contra-indications. In my opinion the only one that ought to be considered as such is a low degree of vitality of the patient. If she be reduced by hemorrhage, by a very protracted confinement, or other conditions complicating the act of labor, it would be unreasonable to insist upon immediate interference. The extent of the rupture itself should never be counted as an indication for delaying the operation. The reasons that call for an operation in a perineum ruptured up to the sphincter ani, gain in value in proportion to the extent of the rupture. It is a well-known fact that

the causes of rupture must be sought more in the condition of the tissues forming the perineum, than in the duration of labor; by which I mean to indicate that a very extensive rupture far up into the vagina by no means coincides in the majority of cases with a very low amount of vitality.

Another contra-indication, which has been urged by several obstetricians, is the danger of puerperal fever spreading from the canal of the sutures, especially at the time of their removal. If this were really the case, we ought to be especially careful in New York, where we see so much of the fever almost every year. I have looked over the several works at my disposal to find an answer to this question, and I found it in the above-named report of the St. Petersburg Lying-in Hospital of Dr. Sutigin.

Of sixteen cases of rupture, where no operation was performed, 6 per cent. remained free from puerperal fever, while among twenty-six cases which were operated 14 per cent. remained healthy—and while 12 per cent. died from it among the former, only 7 per cent. had a fatal issue among the latter.

Thus patients in whom a perineal rupture is united immediately after the accident, stand the best chance in an epidemic of childbed fever. And it is reasonable to expect that the closing up of the torn edges should diminish the surface from which septic deposits may be absorbed or even developed. Hence the prevalence of puerperal fever would rather establish an indication for immediate operation than otherwise

Now after all these considerations I think I will not be expected to dilate on other minor objections that have been urged against immediate interference; the fact, for instance, that the accoucheur was usually on such an occasion not provided with the necessary surgical apparatus, or that he was not skilled enough to perform the operation. In the first instance he has to send for his pocket-case, and in the second, for a more competent surgeon.

With regard to my own experience I must say that when I began to practice in this city I was imbued with the doctrines which were taught seventy years ago, that it was useless to attempt union by an operation immediately after the accident. Of late years, however, I have operated upon every case where the general condition of the patient was such as to present no contra-indication against the use, or rather continuance of chloroform. I have made it a rule to give chloroform when the head is impinging upon the perineum in every case where I expect a rupture to take place, in order to have the operation performed before the patient is allowed to become conscious, or to spare her the pain of the lateral incisions, in case I should decide to employ them. Since I have no statistics to offer, I

will state from memory, that in most instances the result was satisfactory, and that in those cases where union did not take place, this was owing, in one set of cases, to a want of reaction in the tissues involved, and on the other hand, the result of an insufficient number of sutures.

I will briefly state that, except the paring of the edges, the method of operating is the same as that employed in ruptures of old standing.

The last operation which I performed is an example of the faultiness of the recommendation to keep the bowels confined as long as possible. The patient was delivered on the 20th of September, 1874, after an easy labor of six hours. A rupture, which had existed from the last confinement, and involved even part of the sphincter ani muscle, was enlarged by this second labor so as to tear through the sphincter, and to some extent into the vagina. She was put at once under the influence of chloroform, and the operation performed in the ordinary manner, six sutures having been applied. I kept the bowels confined, because the patient had been subject to chronic diarrhœa for many months after the last labor. On the 26th I removed a few of the vaginal and perineal sutures; the parts had united completely. In the night of the 28th the patient had a spontaneous evacuation of the size of a large fist, and when I arrived to examine the parts, I found that the rupture was as bad as on the first day of the accident. By great care and the use of irrigations, repeated every three hours, the wound in the rectum healed by granulation sufficiently to keep the patient perfectly comfortable; and up to the present time she has had very little inconvenience from the almost complete absence of the perineum.

Dr. Paul F. Mundé read a

REPORT OF THE NUMBER OF CASES OF PERINEAL RUPTURE WHICH OCCURRED IN THE WÜRZBURG LYING-IN HOSPITAL FROM 1863 TO 1870, THE MANNER AND RESULT OF THEIR TREATMENT, AND THE MEANS USED FOR THEIR PREVENTION.

Among 2,560 deliveries, about 1,200 of which occurred under Dr. Mundé's personal supervision, or while he was resident physician to the hospital, there were 44 lacerations of the perineum, that is one in 58 cases = 1.72 per cent. Of these lacerations 38 occurred in primiparæ, 6 in multiparæ, 43 in vertex, one in a breech presentation. This last case was in a primipara with very narrow vulva and long perineum, in whom the breech, which had been stationary at the pelvic outlet for 24 hours, was manually extracted; notwithstanding bilateral

incision of the vulvar border (episiotomy) the perineum ruptured in ʌ shape down to and on either side of the sphincter, without injuring that muscle; five sutures were applied and complete union ensued. Two of the 44 lacerations occurred in forceps cases. Of these 44 lacerations 34 were treated by immediate union with the interrupted suture, well-waxed double thread or silk being used. In one case one suture was applied, nine times, two; seven times, three; six times, four, and three times, five sutures; in eight cases the number of sutures is not noted. The legs of the patients were kept constantly tied together, they were directed to occupy the lateral decubitus as much as possible, the bowels were kept confined until the day of removal of the stitches, generally the fourth or fifth day, and then opened by copious enemata. The urine was for a time drawn twice a day, but finding that the operation of catheterization necessitated more manipulation of the parts than seemed advisable, fearing also the danger of causing cystitis by the introduction of lochial fluid into the bladder by means of the catheter, especially as a sufficient separation of the labia was inexpedient on account of the laceration, Dr. Mundé preferred to allow the patients to urinate freely over the perineum, irrigating the parts immediately afterwards with warm water, and found this method much more satisfactory. In 10 cases no treatment was adopted, either because the lacerations were too slight in extent to require it, or because a syphilitic diathesis and the presence of broad condylomata on the perineum rendered a union by first intention improbable. In 11 of these 34 cases there was complete, in 7 only partial union: 18 out of 34 = 55.5 per cent., about the usual average in hospital practice.

Among 448 confinement cases of which Dr. Mundé has accurate notes, there are mentioned only nine instances of episiotomy. He is confident that this operation was performed much more frequently, probably 40 or 50 times, but was considered too unimportant to require notice except in special cases. It was customary during the time of service of Dr. Mundé's predecessor, as well as during his own, to keep the scissors close at hand with every primipara in whom the perineum appeared likely to yield to the strain occurring during the passage of the presenting part; as soon as the distention and pallor of the perineum indicated that that part had reached the point when the slightest increase of distention would result in its rupture, the blunt point of the scissors was inserted from ¼″ to ½″ under the sharp border of the vulva, about 1″ from the perineal raphé, and the skin and subcutaneous cellular tissue divided until the white glistening fibrous fascia ap-

peared. This incision, if necessary, was repeated on the other side of the raphé. There can be no question that these slight incisions saved a number of perinea; Dr. Mundé had too often seen their value to feel any hesitation in expressing this conviction. The incisions, although occasionally appearing large at the moment, diminished so much in size during puerperal involution as hardly to be noticeable; once only was it found necessary to apply a suture, and once a small branch of the common pudic artery was divided, requiring torsion. Notwithstanding bilateral episiotomy, four lacerations of the perineum occurred, one in cicatricial tissue, the residue of broad condylomata, and three in very high perinea.

Dr. Noeggerath, in his remarks this evening, recommends very justly the method of preventing perineal laceration by supporting the perineum, and pushing the presenting part towards the symphysis by means of two fingers in the rectum—a method formerly described by Ritgen, and lately revived by Dr. Wm. Goodell, of Philadelphia, and Dr. Frederick Ahlfeld, of Leipzig. Dr. Mundé said that he had no doubt that this was the best and, perhaps, only really efficacious mode of supporting the perineum during labor, but he wished to call attention to two accidents which he had seen happen, and which should be guarded against: 1. The flexible parietal bones of the fœtal cranium may be indented by too strong pressure with the two fingers in the rectum, a circumstance which happened to him in one instance, the slight depression disappearing without subsequent evil consequences in a few days; and 2. The laceration of the soft spongy cavernous tissue at the anterior commissure of the vulva in consequence of the too strong pressure of the head against the symphysis, and the over-distention of the soft parts by the broad fœtal occiput.

He had seen this accident happen in a primipara, in whom the attending midwife supported the perineum in the usual manner by pressing the hand againt the part from the outside; notwithstanding this support a laceration of the perineum occurred, and when Dr. Mundé was called to examine and unite it, he found a profuse hemorrhage taking place, as he first thought, from the lacerated perineum. On carefully sponging off the parts, however, the blood was found to proceed from a deep fissure, nearly 2″ in length, through the cavernous venous tissue to the left of the clitoris. Styptics and pressure were applied in vain, and the hemorrhage was not arrested until the whole bleeding surface was taken up *en masse* and ligated, by which time the patient had lost quite a large amount of blood; she made a good recovery.

This case is reported by Dr. Peter Müller, in *Scanzoni's*

Beiträge, vol. vii., p. 201, together with five cases of his own (three described in vol. vi., p. 148), in three of which the patient succumbed to the hemorrhage from the ruptures between the clitoris and the urethra.

In reply to an objection made by Dr. M. D. Mann to the operation of episiotomy, that the incision, besides being very painful, might become the seat of septic infection and diphtheritic deposit, Dr. Mundé said that he had performed the operation very often, never with bad results; that small abrasions and lacerations of the vaginal entrance occur almost in every labor, from which septic infection might readily take place if there were any disposition to such an accident, and that one or two small incised episiotomy wounds would not increase that disposition; the pain of the incision is so momentary that it is scarcely felt by the patient during the greater agony of the termination of the second stage of labor. Of course the operation should be performed only when there appears no other chance of saving the perineum; that it is much to be preferred to a perineal rupture scarcely needs mention.

He had seen one case of *superficial* rupture of the perineum in a woman, the skin of whose perineum had been converted into cicatricial tissue by broad condylomata; in this instance he distinctly saw the cicatricial integument crack in a longitudinal direction as the head distended the perineum, and this superficial rupture extended to double the extent of the moderate actual complete rupture. He would ask whether it is justifiable not to treat by immediate suture a perineal laceration in a syphilitic person, or whether it should be united and the chance given it to heal. He thought the latter, for he had in Germany treated several bad sabre wounds of students, who were notoriously syphilitic, by the immediate suture, and had seen them heal by first intention.

Dr. Noeggerath said that it was a common surgical rule not to operate in syphilitic cases, until the syphilitic taint had been at least apparently removed. This applies to secondary operations. A certain diseased condition of the arterial coats in syphilis (which has thus far, however, been observed only in the cerebral arteries), would appear to prevent union of the wound. In a fresh wound, such as laceration of the perineum, he does not think that we would be justified in refusing the operation merely on account of syphilis, although there is less chance of success. Sigmund, of Vienna, however, asserts that wounds in syphilitic persons heal quite as readily as in healthy people.

Dr. Byrne related a case of laceration 2″ up the recto-vaginal septum, which occurred some three months ago during

labor. The patient was too much exhausted to permit an immediate operation. The laceration has gradually united spontaneously, and the woman has now almost recovered the use of her sphincter ani.

CONTINUATION OF THE DISCUSSION ON THE TREATMENT OF PERINEAL LACERATION.

Dr. Mann said that, as the subject of immediate treatment of rupture of the perineum had excited some attention of late in the Society, he would like to present one of the serre-fines, the employment of which he had recommended in his article in the American Journal of Obstetrics for November, 1874. This one came from Vienna. It would be seen that it was not, as Dr. Lente had said in his paper, a *very strong* serre-fine, the spring of this one being quite weak.

Dr. Mann did not think that Dr. Noeggerath's figures in his paper as read at the last meeting, were quite fair. He had certainly shown that the result obtained by some form of operation were much better than could be expected where we were merely content with tying the knees together and enjoining rest. But he did not think that the superiority of the suture over the serre-fines was so clearly established as Dr. Noeggerath would lead us to believe. Dr. Noeggerath had counted 115 cases reported by Winckel as being all cured, because nothing was said to the contrary. This was hardly fair, however, as the reports of previous years from the same institution had not shown any such results. It could hardly be expected that they would jump from 38 cures in 45 cases to 101 cures in 101 cases (14 were so slight as not to require suture). Leaving out then these cases, the percentage of cure is reduced to 56 per cent., while by serre-fines the cures had been about 38 per cent. Hoogeweg, however, reported 27 cures in 35 cases, or 77 per cent. by the serre-fines. It was hardly fair to conclude because one man obtained no success, and another very poor results from the use of the clamps, that it was the fault of the instrument. The fault lay rather in the operator, or how could one get so much better results than another? Perhaps, also, the springs were too stiff, or they were not properly applied. At any rate, the fact remained that 77 per cent. had been cured, and what one man had done, another could do. Dr. Mann hoped that the clamps would be tried by the profession in this country, and that the subject would be discussed until some definite plan was decided on.

Dr. Noeggerath said that he had had some hesitation in admitting the 115 cases into his statistics, but had been led to do

so from the fact that a very careful report of the condition of the genital organs of each patient was given before she left the hospital, and nothing was said about rupture. He therefore thought they could be safely counted as cured. As to serre-fines he thought they occupied the same position in the treatment of rupture of the perineum as they did in general surgery; twenty years ago they were in general use, but were now abandoned, because it was found that they did not unite the deeper tissues, only the skin being held in apposition, while the muscles were allowed to retract and consequently did not unite.

Dr. Mann said that he did not think the cases were parallel. In the perineum after labor the tissues were all relaxed, and if the patient were placed on her side or the knees kept together the entire surface of the wound was brought in contact. That was why we had so many cases of spontaneous union. The only danger was that they would slide or slip one on the other, and that they would gape, and this was prevented by the serres-fines.